Connecticut Department of Social Services

Making a Difference

Testimony before the Human Services Committee

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Commissioner
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Good afternoon, Senator Doyle, Representative Walker and Members of the Human Services Committee. I am Michael Starkowski, Commissioner of the Department of Social Services. I am pleased to be here to present testimony on a number of bills on today's agenda.

S.B. No. 370 (RAISED) AN ACT CONCERNING MEDICAID LONG-TERM CARE COVERAGE FOR MARRIED COUPLES.

Section 1 requires that the department disregard the maximum amount of assets permitted under federal law for the benefit of a non-institutionalized spouse of an applicant for long-term care Medicaid assistance. Under this proposal, the department would automatically disregard all of the assets of a married couple up to $109,560 for the benefit of the non-institutionalized spouse. Since 1989, Connecticut, under federal law, has disregarded one-half of a married couple's assets (excluding the home and one car) for the benefit of a non-institutionalized spouse of a long-term care Medicaid applicant, up to a maximum of $109,560.

The department opposes this proposed change as the disregard of additional assets would divert funds that are presently used to pay for long-term care services, resulting in earlier findings of Medicaid eligibility and thus increasing Medicaid costs to the state. Under current regulations, non-institutionalized spouses keep the home, one car and one-half of the couple's assets (with a minimum amount of $21,912) without affecting the institutionalized spouse's eligibility for long-term care Medicaid assistance. We believe that these assets are sufficient to support the needs of the non-institutionalized spouse and do not need to be increased at the expense of the Medicaid program.

Section 2 would exclude funds derived from equity in home property through a reverse annuity mortgage loan or other home equity conversion loan in determining Medicaid eligibility. Currently, such funds are not counted in the month in which they are received; however, any funds retained after the initial month of receipt are counted as assets, which could result in the loss of Medicaid eligibility. Excluding these funds could allow individuals to use these funds to support themselves in the community for greater amounts of time and avoid costly nursing facility care. The language as drafted, however, is inaccurate as it excludes these funds as "income." Instead, these funds should be excluded as "assets."

The department feels that section 2 of the bill has merit however, cannot support the legislation if it includes section 1 due to its costs.

S.B. No. 391 (RAISED) AN ACT CONCERNING CHILD CARE SUBSIDIES FOR THE UNEMPLOYED UNDER THE CARE 4 KIDS PROGRAM.

The bill would require the department to complete a C4K application within 30 days after receipt of such application. Our existing goal is to process all "properly completed applications" applications within 30 days. However, our data shows that this timeframe is very difficult to meet and is dependent on the client and the child care provider submitting the proper information. Often it can take up to 3 submissions to collect the proper information to complete an application. During our efforts to obtain the correct required information, we hold the original date of application as the start date, in the event that the client is determined eligible.

Because there is no statutory timeframe, we are able to keep the application in pending status. Should this provision be enacted, if the required information is not received from the applicant or provider within the 30-day timeframe, the department would deny the application for failure to comply. Therefore, applicants would be required to reapply and start the process all over. In this scenario if the applicant is denied, the provider may be out payments if they provided services while the initial application was pending.

H.B. No. 5296 (RAISED) AN ACT CONCERNING THE DEFINITION OF MEDICAL NECESSITY.

The bill before you is based on earlier draft language proposed by the Medical Inefficiency Committee established under PA 09-5. Although the Department does not support the bill as drafted, we have been working with the Medical Inefficiency Committee on amendments to the bill that would enable the Department to reduce medical inefficiency consistent with legislative intent. We would like to work with members of the committee to amend the language to the most current recommendation from the Medical Inefficiency Committee. The Department supports ongoing monitoring of the impact of a new definition with respect to its impact on inefficiency and quality of care.

H.B. No. 5398 (RAISED) AN ACT CONCERNING A PILOT PROGRAM TO TRANSFER HOSPITAL PATIENTS WHO RECEIVE MEDICAID BENEFITS TO NURSING HOMES IN A TIMELY MANNER.

This bill would create a pilot program to decrease the period of time that Medicaid recipients who require long-term care remain hospitalized before transfer to a long-term care facility. All Medicaid applicants who are seeking admission to a long-term care facility must be screened for the potential existence of mental illness or mental retardation, known as Pre-Admission Screening/Resident Review (PASRR), prior to being placed in a nursing facility. If there is evidence of mental illness or mental

retardation (MI/MR), a second level of review must occur that includes a face-to-face evaluation by a mental health professional or a nurse consultant from the Department of Developmental Services. If this review is not done prior to hospital discharge to the nursing facility, the nursing facility is out of compliance with federal regulations and Medicaid cannot pay for the nursing home stay without jeopardizing federal reimbursement.

The department has begun to roll out a more streamlined PASRR and level of care screening system. For example, for discharges of persons with MI/MR, who require nursing home care for 30 days or less, nursing home admission will be expedited and such persons can be discharged to nursing homes under this provision on a 24-hour, seven-day-a-week basis.

The department feels that our current initiatives are improving the screening process and providing for more timely transfers and therefore this bill is unnecessary.

H.B. No. 5399 (RAISED) AN ACT CONCERNING NOTICE BY THE DEPARTMENT OF SOCIAL SERVICES REGARDING REPAYMENT FOR SERVICES.

This department is opposed to this bill because we already provide such notification, therefore feel it is unnecessary. When an individual or family applies for benefits the information regarding recovery and liens is disclosed on the application in plain language that is readable and understandable. By signing the application the applicant is acknowledging that he/she has read these provisions and understands that he/she are subject to them. A copy of the disclosure page of our application is attached to my testimony.

H.B. No. 5411 (RAISED) AN ACT CONCERNING MEDICAID.

This legislation seeks to resume the provision of podiatry and implement smoking cessation as state plan services.

Both podiatry services and tobacco cessation services are valuable health services and the addition of each to the state plan is a laudable goal. Unfortunately, addition of both services will require additional financial resources which are unavailable in the current fiscal climate.

Section 6 of this bill would require the Commissioner of Social Services to apply for an 1115 waiver to convert the state-funded portion of the CT Home Care for Elders Program to Medicaid. The Department believes an evaluation of the viability of such a proposal needs to be examined prior to a statutory requirement to implement. One of the basic requirements of an approvable 1115 waiver is cost savings to the federal government; this is a cost-effectiveness requirement. Based on the existing eligibility and other payment criteria, it is not clear that this cost-effectiveness requirement can be met.

H.B. No. 5412 (RAISED) AN ACT TO MOVE HOSPITAL UNCOMPENSATED CARE FUNDS AND URBAN DISPROPORTIONATE SHARE HOSPITAL FUNDS INTO THE FUND FOR HOSPITAL MEDICAID RATES.

This bill would transfer the unexpended balance of funds in the accounts Disproportionate Share - Medical Emergency Assistance, DSH - Urban Hospitals in Distressed Municipalities and Connecticut Children's Medical Center to Medicaid Rates - Hospitals for the fiscal year ending June 30, 2010, for the sole purpose of obtaining ARRA-enhanced federal matching funds pursuant to anticipated changes in federal law. The proposal has several problems, as follows:

1. Based on a hold harmless theory, the DSH funds would need to be apportioned to rates such that no hospital would gain or lose revenue relative to the existing arrangement under DSH. This change would require CMS approval and we feel it would be highly unlikely that CMS would support a rate methodology with this as its primary objective. To the best of our knowledge, no other states have attempted a transfer of this type for the purpose of maximizing revenue under ARRA.
2. In order to take advantage of the enhanced match rate available under ARRA, the increase would need to be limited to Medicaid rates under Medicaid fee-for-service and the HUSKY program. This would require that the Department revise the actuarially sound rate range for the HUSKY program and obtain approval from CMS for this revised rate range prior to the effective date of April 1, 2010. Conducting the necessary analyses and receiving CMS approval cannot realistically be completed in this timeframe.
3. If health care reform is passed, it will likely extend Medicaid to the SAGA program and to uninsured single adults up to 130% of the federal poverty level. If Medicaid hospital rates are increased under the proposed bill based on current enrollment and utilization, the cost to the state of extending hospital coverage to this new covered population will be substantially greater than it would be if hospital rates remained at today's level.
4. Proponents of this bill may argue that the proposed rate increases will be temporary; however, we would have to provide documentation to CMS that the "temporary" rates are appropriate, then at a later date we would have to provide a contradictory justification for reducing the rates.

Implementing this legislation may put the state at legal risk of continuing the "temporary" rates and have the adverse fiscal impact noted above.

H.B. No. 5431 (RAISED) AN ACT CONCERNING THE ADMINISTRATION OF PROGRAMS INVOLVING THE DEPARTMENT OF SOCIAL SERVICES.

Sec. 2 of the bill would amend the requirement to provide notice every three years to parents subject to a support order to inform them of their right to a review of the order. Notice of the right to review is already included every year in an annual notice sent to the

parents subject to a child support order in IV-D (child support enforcement) cases. The bill would require more specific language regarding incarceration and change of employment status. Such language could be included, and would not adversely impact the IV-D program either fiscally or programmatically, but is already addressed in general terms by the existing language.

Sec. 3 would add a time frame for payment to be made to contractor or provider programs (this is the DSS child care quality enhancement statutes where we distribute funds from). The ability of the department to make these funds available is dependent on numerous state agency reviews that are entirely outside of our control. For instance, as was the case last year, the state budget did not pass until September and as a result DSS would not have been able to release funds by August 1. Furthermore, this process is dictated by statutory contracting requirements which cannot be circumvented and take time.

Sec. 4 would increase the handling charge for the distribution of bulk foods by the CT Food Bank to soup kitchens, pantries and shelters. We acknowledge that the current handling charge has not been updated in over 20 years. While we understand the rationale for this increase, we are concerned that the increase in costs to soup kitchens, pantries and shelters may negatively impact their operating budgets and require additional funding from DSS. At the present time, the state does not have the additional resources to honor such an increase.

S.B. 282 - AN ACT CONCERNING IMPLEMENTATION OF AN ATTENDANCE-BASED RATE SYSTEM BY THE DEPARTMENT OF DEVELOPMENTAL SERVICES.

The Department of Social Services opposes Senate Bill No. 282. This bill would reverse the implementation of an attendance-based reimbursement system for DDS day service providers that was put in place on February 1, 2010.

As the single state Medicaid agency, the Department of Social Services is responsible for oversight of the DDS home and community based Medicaid waivers. We are responsible for setting rates for services and for claiming Medicaid waiver expenditures in order to receive federal financial participation for the DDS Medicaid waivers. In this capacity, the department is the lead agency responsible for establishing uniform and consistent rate setting and federal claiming methodologies that are consistent with CMS reimbursement policy

Over the past several years, we have seen CMS repeatedly, and on a national level, adopt program requirements which align federal financial reimbursement with clear and uniform billing practices that are directly related to and traceable to actual services provided.

Through the implementation of an attendance based payment system, DDS has adopted a claiming system which is in line with federal expectations, linking billing units to specific

services provided. Not only will this new claiming methodology improve the state's Medicaid rate setting process and claiming methodology, it will allow the state to better withstand scrutiny from CMS and the Office of Inspector General related to the claiming of Medicaid services. Should DDS revert its methodology from attendance based to grant based reimbursement, there is a potential for a partial federal disallowance of federal financial participation.

Therefore, we oppose Senate Bill No 282 which would delay the implementation of these improvements. The home and community based waivers provide approximately $300,000,000 in revenue to the state and the Medicaid rate setting and claiming methodology utilized must be accurate and defensible.

Thank you for the opportunity to testify today and I would be happy to answer any questions from the committee.

FOR STATE SUPPLEMENT

I understand and agree to the following:

- Inheritance money or money from a pending lawsuit will be assigned to the State.
- The State will place a lien against my home and the property of my spouse.
- I will be required to grant the department a security mortgage on the non-home property that I own.
- The State recovers monies from the estates of individuals who received cash assistance.
- My legally liable relative may be billed to repay the State for cash assistance paid to me.
- The State may recover an amount up to the total amount of benefits paid if I or anyone for whom I receive assistance receives money at a future date from sources including but not limited to lottery winnings, an inheritance, settlement of a lawsuit or the sale of property.

FOR SAGA CASH AND SAGA MEDICAL ASSISTANCE

I understand and agree to the following:

- Inheritance money or money from a pending lawsuit will be assigned to the State.
- The State will place a lien against my home. The State will also place a lien against the property of the spouse or parent of any member of the household. I understand that I will be required to grant the department a security mortgage on the non-home property that I own.
- The State may recover an amount up to the total amount of benefits paid if I, my spouse, or anyone for whom I receive assistance receives money at a future date from sources including, but not limited to, lottery winnings, an inheritance, settlement of a lawsuit or the sale of property.
- I must cooperate with the State in securing support from spouses and/or parents of all household members.
- If a member of my household has a substance abuse problem, he or she may be required to be in treatment in order to receive cash benefits.
- False or misleading statements made when applying for SAGA violate State law and may cause me to be disqualified for up to one year.

FOR ALL MEDICAL, MONEY AND HOME CARE PROGRAMS

I understand and agree to the following:

- Money from a pending lawsuit will be assigned to the State to recover any medical expenses paid by the State related to the lawsuit.
- False or misleading statements made when applying for Medical Assistance violate federal law and may be punishable by a fine up to $25,000 or imprisonment for 5 years, or both.
- By applying for assistance, I assign my right of support from third parties to the department (section 1912 of the Social Security Act). I also understand that, if I am in a nursing facility or if I am applying for home and community-based services, and I want to assign my support rights, I must sign an additional assignment of support (section 1924 of the Social Security Act).
- By receiving medical assistance, I allow the State to recover the cost of my medical bills which may have been covered by other insurance directly from the insuring company.
- The State recovers monies from the estates of individuals who received long term care services, Home Care Services or who were age 55 or older at the time that community medical assistance benefits were paid and who do not have a living spouse or a surviving child who is under age 21 or blind or disabled.
- I give the Department of Social Services permission to apply for Medicare on my behalf. I understand that an application will be filed only if the department thinks I am eligible. I also agree to let the Department of Social Services file Medicare claims and pursue appeals. These actions may be taken by the department or its representative.
- I give permission to DSS or any health insurer, provider, or any other entity providing services to me or my family under the Medicaid program to release information about me or my family as necessary for the delivery of Medicaid program services and the administration of the Medicaid program, as permissible by federal or State law.
- I will not alter, trade, sell, or use someone else's medical services identification card.
- The State can place a lien, under certain conditions, on my home if I permanently enter a nursing facility.
- My legally liable relative may be billed to repay the State to repay the cost of my medical care.